



Senate

General Assembly

File No. 561

January Session, 2013

Substitute Senate Bill No. 848

Senate, April 18, 2013

The Committee on Public Health reported through SEN. GERRATANA of the 6th Dist., Chairperson of the Committee on the part of the Senate, that the substitute bill ought to pass.

AN ACT IMPLEMENTING PROVISIONS OF THE BUDGET CONCERNING PUBLIC HEALTH.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

1 Section 1. Section 19a-491 of the general statutes is repealed and the
2 following is substituted in lieu thereof (*Effective July 1, 2013*):

3 (a) No person acting individually or jointly with any other person
4 shall establish, conduct, operate or maintain an institution in this state
5 without a license as required by this chapter, except for persons issued
6 a license by the Commissioner of Children and Families pursuant to
7 section 17a-145 for the operation of (1) a substance abuse treatment
8 facility, or (2) a facility for the purpose of caring for women during
9 pregnancies and for women and their infants following such
10 pregnancies. Application for such license shall be made to the
11 Department of Public Health upon forms provided by it and shall
12 contain such information as the department requires, which may
13 include affirmative evidence of ability to comply with reasonable
14 standards and regulations prescribed under the provisions of this

15 chapter. The commissioner may require as a condition of licensure that
16 an applicant sign a consent order providing reasonable assurances of
17 compliance with the Public Health Code. The commissioner may issue
18 more than one chronic disease hospital license to a single institution
19 until such time as the state offers a rehabilitation hospital license.

20 (b) If any person acting individually or jointly with any other person
21 owns real property or any improvements thereon, upon or within
22 which an institution, as defined in subsection (c) of section 19a-490, is
23 established, conducted, operated or maintained and is not the licensee
24 of the institution, such person shall submit a copy of the lease
25 agreement to the department at the time of any change of ownership
26 and with each license renewal application. The lease agreement shall,
27 at a minimum, identify the person or entity responsible for the
28 maintenance and repair of all buildings and structures within which
29 such an institution is established, conducted or operated. If a violation
30 is found as a result of an inspection or investigation, the commissioner
31 may require the owner to sign a consent order providing assurances
32 that repairs or improvements necessary for compliance with the
33 provisions of the Public Health Code shall be completed within a
34 specified period of time or may assess a civil penalty of not more than
35 one thousand dollars for each day that such owner is in violation of the
36 Public Health Code or a consent order. A consent order may include a
37 provision for the establishment of a temporary manager of such real
38 property who has the authority to complete any repairs or
39 improvements required by such order. Upon request of the
40 Commissioner of Public Health, the Attorney General may petition the
41 Superior Court for such equitable and injunctive relief as such court
42 deems appropriate to ensure compliance with the provisions of a
43 consent order. The provisions of this subsection shall not apply to any
44 property or improvements owned by a person licensed in accordance
45 with the provisions of subsection (a) of this section to establish,
46 conduct, operate or maintain an institution on or within such property
47 or improvements.

48 (c) Notwithstanding any regulation to the contrary, the

49 Commissioner of Public Health shall charge the following fees for the
50 biennial licensing and inspection of the following institutions: (1)
51 Chronic and convalescent nursing homes, per site, four hundred forty
52 dollars; (2) chronic and convalescent nursing homes, per bed, five
53 dollars; (3) rest homes with nursing supervision, per site, four hundred
54 forty dollars; (4) rest homes with nursing supervision, per bed, five
55 dollars; (5) outpatient dialysis units and outpatient surgical facilities,
56 six hundred twenty-five dollars; (6) mental health residential facilities,
57 per site, three hundred seventy-five dollars; (7) mental health
58 residential facilities, per bed, five dollars; (8) hospitals, per site, nine
59 hundred forty dollars; (9) hospitals, per bed, seven dollars and fifty
60 cents; (10) nonstate agency educational institutions, per infirmary, one
61 hundred fifty dollars; [and] (11) nonstate agency educational
62 institutions, per infirmary bed, twenty-five dollars; (12) home health
63 care agencies, except certified home health care agencies described in
64 subsection (d) of this section, per agency, three hundred dollars; (13)
65 home health care agencies, except certified home health care agencies
66 described in subsection (d) of this section, per satellite patient service
67 office, one hundred dollars; and (14) assisted living services agencies,
68 except such agencies participating in the congregate housing facility
69 pilot program described in section 8-119n, per site, five hundred
70 dollars.

71 (d) Notwithstanding any regulation, the commissioner shall charge
72 the following fees for the triennial licensing and inspection of the
73 following institutions: (1) Residential care homes, per site, five
74 hundred sixty-five dollars; [and] (2) residential care homes, per bed,
75 four dollars and fifty cents; (3) home health care agencies that are
76 certified as a provider of services by the United States Department of
77 Health and Human Services under the Medicare or Medicaid program,
78 three hundred dollars; and (4) certified home health care agencies, as
79 described in section 19a-493, per satellite patient service office, one
80 hundred dollars.

81 (e) The commissioner shall charge one thousand dollars for the
82 licensing and inspection every four years of outpatient clinics that

83 provide either medical or mental health service, and well-child clinics,
84 except those operated by municipal health departments, health
85 districts or licensed nonprofit nursing or community health agencies.

86 (f) The commissioner shall charge a fee of five hundred sixty-five
87 dollars for the technical assistance provided for the design, review and
88 development of an institution's construction, renovation, building
89 alteration, sale or change in ownership, when the cost of such project is
90 one million dollars or less and one-quarter of one per cent of the total
91 project cost when the cost of such project is more than one million
92 dollars. Such fee shall include all department reviews and on-site
93 inspections. For purposes of this subsection, "institution" does not
94 include a facility owned by the state.

95 (g) The commissioner may require as a condition of the licensure of
96 home health care agencies and homemaker-home health aide agencies
97 that each agency meet minimum service quality standards. In the
98 event the commissioner requires such agencies to meet minimum
99 service quality standards as a condition of their licensure, the
100 commissioner shall adopt regulations, in accordance with the
101 provisions of chapter 54, to define such minimum service quality
102 standards, which shall (1) allow for training of homemaker-home
103 health aides by adult continuing education, (2) require a registered
104 nurse to visit and assess each patient receiving homemaker-home
105 health aide services as often as necessary based on the patient's
106 condition, but not less than once every sixty days, and (3) require the
107 assessment prescribed by subdivision (2) of this subsection to be
108 completed while the homemaker-home health aide is providing
109 services in the patient's home.

110 (h) On and after June 15, 2012, until June 30, 2017, the commissioner
111 shall not issue or renew a license under this chapter for any hospital
112 certified to participate in the Medicare program as a long-term care
113 hospital under Section 1886(d)(1)(B)(iv) of the Social Security Act (42
114 USC 1395ww) unless such hospital was so certified under said federal
115 act on January 1, 2012.

116 Sec. 2. Section 19a-88 of the general statutes is repealed and the
117 following is substituted in lieu thereof (*Effective October 1, 2013*):

118 (a) Each person holding a license to practice dentistry, optometry,
119 midwifery or dental hygiene shall, annually, during the month of such
120 person's birth, register with the Department of Public Health, upon
121 payment of the professional services fee for class I, as defined in
122 section 33-182l, plus five dollars, in the case of a dentist, except as
123 provided in sections 19a-88b and 20-113b; [.] the professional services
124 fee for class H, as defined in section 33-182l, in the case of an
125 optometrist, fifteen dollars in the case of a midwife; [.] and one
126 hundred dollars in the case of a dental hygienist. [.] Such registration
127 shall be on blanks to be furnished by the department for such purpose,
128 giving such person's name in full, such person's residence and
129 business address and such other information as the department
130 requests. Each person holding a license to practice dentistry who has
131 retired from the profession may renew such license, but the fee shall be
132 ten per cent of the professional services fee for class I, as defined in
133 section 33-182l, or [ninety] ninety-five dollars, whichever is greater.
134 Any license provided by the department at a reduced fee pursuant to
135 this subsection shall indicate that the dentist is retired.

136 (b) Each person holding a license to practice medicine, surgery,
137 podiatry, chiropractic or natureopathy shall, annually, during the
138 month of such person's birth, register with the Department of Public
139 Health, upon payment of the professional services fee for class I, as
140 defined in section 33-182l. [.] Each person holding a license to practice
141 medicine or surgery shall pay five dollars in addition to such services
142 fee. Such registration shall be on blanks to be furnished by the
143 department for such purpose, giving such person's name in full, such
144 person's residence and business address and such other information as
145 the department requests.

146 (c) (1) Each person holding a license to practice as a registered
147 nurse, shall, annually, during the month of such person's birth, register
148 with the Department of Public Health, upon payment of one hundred

149 five dollars, on blanks to be furnished by the department for such
150 purpose, giving such person's name in full, such person's residence
151 and business address and such other information as the department
152 requests. Each person holding a license to practice as a registered nurse
153 who has retired from the profession may renew such license, but the
154 fee shall be ten per cent of the professional services fee for class B, as
155 defined in section 33-182l. Any license provided by the department at a
156 reduced fee shall indicate that the registered nurse is retired.

157 (2) Each person holding a license as an advanced practice registered
158 nurse shall, annually, during the month of such person's birth, register
159 with the Department of Public Health, upon payment of one hundred
160 [twenty] twenty-five dollars, on blanks to be furnished by the
161 department for such purpose, giving such person's name in full, such
162 person's residence and business address and such other information as
163 the department requests. No such license shall be renewed unless the
164 department is satisfied that the person maintains current certification
165 as either a nurse practitioner, a clinical nurse specialist or a nurse
166 anesthetist from one of the following national certifying bodies which
167 certify nurses in advanced practice: The American Nurses' Association,
168 the Nurses' Association of the American College of Obstetricians and
169 Gynecologists Certification Corporation, the National Board of
170 Pediatric Nurse Practitioners and Associates or the American
171 Association of Nurse Anesthetists. Each person holding a license to
172 practice as an advanced practice registered nurse who has retired from
173 the profession may renew such license, but the fee shall be ten per cent
174 of the professional services fee for class C, as defined in section 33-182l,
175 plus five dollars. Any license provided by the department at a reduced
176 fee shall indicate that the advanced practice registered nurse is retired.

177 (3) Each person holding a license as a licensed practical nurse shall,
178 annually, during the month of such person's birth, register with the
179 Department of Public Health, upon payment of [sixty] sixty-five
180 dollars, on blanks to be furnished by the department for such purpose,
181 giving such person's name in full, such person's residence and
182 business address and such other information as the department

183 requests. Each person holding a license to practice as a licensed
184 practical nurse who has retired from the profession may renew such
185 license, but the fee shall be ten per cent of the professional services fee
186 for class A, as defined in section 33-182l, plus five dollars. Any license
187 provided by the department at a reduced fee shall indicate that the
188 licensed practical nurse is retired.

189 (4) Each person holding a license as a nurse-midwife shall, annually,
190 during the month of such person's birth, register with the Department
191 of Public Health, upon payment of one hundred [twenty] twenty-five
192 dollars, on blanks to be furnished by the department for such purpose,
193 giving such person's name in full, such person's residence and
194 business address and such other information as the department
195 requests. No such license shall be renewed unless the department is
196 satisfied that the person maintains current certification from the
197 American College of Nurse-Midwives.

198 (5) (A) Each person holding a license to practice physical therapy
199 shall, annually, during the month of such person's birth, register with
200 the Department of Public Health, upon payment of the professional
201 services fee for class B, as defined in section 33-182l, on blanks to be
202 furnished by the department for such purpose, giving such person's
203 name in full, such person's residence and business address and such
204 other information as the department requests.

205 (B) Each person holding a physical therapist assistant license shall,
206 annually, during the month of such person's birth, register with the
207 Department of Public Health, upon payment of the professional
208 services fee for class A, as defined in section 33-182l, on blanks to be
209 furnished by the department for such purpose, giving such person's
210 name in full, such person's residence and business address and such
211 other information as the department requests.

212 (6) Each person holding a license as a physician assistant shall,
213 annually, during the month of such person's birth, register with the
214 Department of Public Health, upon payment of a fee of one hundred
215 fifty dollars, on blanks to be furnished by the department for such

216 purpose, giving such person's name in full, such person's residence
217 and business address and such other information as the department
218 requests. No such license shall be renewed unless the department is
219 satisfied that the practitioner has met the mandatory continuing
220 medical education requirements of the National Commission on
221 Certification of Physician Assistants or a successor organization for the
222 certification or recertification of physician assistants that may be
223 approved by the department and has passed any examination or
224 continued competency assessment the passage of which may be
225 required by said commission for maintenance of current certification
226 by said commission.

227 (d) No provision of this section shall be construed to apply to any
228 person practicing Christian Science.

229 (e) (1) Each person holding a license or certificate issued under
230 section 19a-514, 20-65k, 20-74s, 20-195cc or 20-206ll and chapters 370 to
231 373, inclusive, 375, 378 to 381a, inclusive, 383 to 383c, inclusive, 384,
232 384b, 384d, 385, 393a, 395, 399 or 400a and section 20-206n or 20-206o
233 shall, annually, during the month of such person's birth, apply for
234 renewal of such license or certificate to the Department of Public
235 Health, giving such person's name in full, such person's residence and
236 business address and such other information as the department
237 requests.

238 (2) Each person holding a license or certificate issued under section
239 19a-514 and chapters 384a, 384c, 386, 387, 388 and 398 shall apply for
240 renewal of such license or certificate once every two years, during the
241 month of such person's birth, giving such person's name in full, such
242 person's residence and business address and such other information as
243 the department requests.

244 (3) Each person holding a license or certificate issued pursuant to
245 section 20-475 or 20-476 shall, annually, during the month of such
246 person's birth, apply for renewal of such license or certificate to the
247 department.

248 (4) Each entity holding a license issued pursuant to section 20-475
249 shall, annually, during the anniversary month of initial licensure,
250 apply for renewal of such license or certificate to the department.

251 (5) Each person holding a license issued pursuant to section 20-
252 162bb shall, annually, during the month of such person's birth, apply
253 for renewal of such license to the Department of Public Health, upon
254 payment of a fee of three hundred fifteen dollars, giving such person's
255 name in full, such person's residence and business address and such
256 other information as the department requests.

257 (f) Any person or entity which fails to comply with the provisions of
258 this section shall be notified by the department that such person's or
259 entity's license or certificate shall become void ninety days after the
260 time for its renewal under this section unless it is so renewed. Any
261 such license shall become void upon the expiration of such ninety-day
262 period.

263 (g) [On or before July 1, 2008, the] The Department of Public Health
264 shall [establish and implement] administer a secure on-line license
265 renewal system for persons holding a license to practice medicine or
266 surgery under chapter 370, dentistry under chapter 379 or nursing
267 under chapter 378. The department shall [allow any such person who
268 renews his or her license using the on-line license renewal system to
269 pay his or her] require such persons to renew their licenses using the
270 on-line renewal system and to pay professional service fees on-line by
271 means of a credit card or electronic transfer of funds from a bank or
272 credit union account. [and may charge such person a service fee not to
273 exceed five dollars for any such on-line payment made by credit card
274 or electronic funds transfer. On or before January 1, 2009, the
275 department shall submit, in accordance with section 11-4a, a report on
276 the feasibility and implications of the implementation of a biennial
277 license renewal system for persons holding a license to practice
278 nursing under chapter 378 to the joint standing committee of the
279 General Assembly having cognizance of matters relating to public
280 health.]

281 Sec. 3. (NEW) (*Effective July 1, 2013*) (a) The Commissioner of Public
282 Health shall, within available appropriations, establish and administer
283 a program to provide financial assistance to community health centers.
284 For purposes of this section, "community health center" means a public
285 or nonprofit private medical care facility that meets the requirements
286 of section 19a-490a of the general statutes and has been designated by
287 the United States Department of Health and Human Services as a
288 federally qualified health center or a federally qualified health center
289 look-alike.

290 (b) The commissioner shall establish a formula to disburse program
291 funds to community health centers. Such formula shall include, but not
292 be limited to, the following factors: (1) The number of uninsured
293 patients served by the community health center; and (2) the types of
294 services provided by the community health center.

295 (c) The commissioner may establish requirements for participation
296 in the program, provided the commissioner provides reasonable notice
297 of such requirements to all community health centers. Community
298 health centers shall use program funds only for purposes approved by
299 the commissioner.

300 Sec. 4. Subsection (a) of section 19a-7j of the general statutes is
301 repealed and the following is substituted in lieu thereof (*Effective July*
302 *1, 2013*):

303 (a) Not later than September first, annually, the Secretary of the
304 Office of Policy and Management, in consultation with the
305 Commissioner of Public Health, shall (1) determine the amount
306 appropriated for the following purposes: (A) To purchase, store and
307 distribute vaccines for routine immunizations included in the schedule
308 for active immunization required by section 19a-7f; (B) to purchase,
309 store and distribute (i) vaccines to prevent hepatitis A and B in persons
310 of all ages, as recommended by the schedule for immunizations
311 published by the National Advisory Committee for Immunization
312 Practices, (ii) antibiotics necessary for the treatment of tuberculosis and
313 biologics and antibiotics necessary for the detection and treatment of

314 tuberculosis infections, and (iii) antibiotics to support treatment of
315 patients in communicable disease control clinics, as defined in section
316 19a-216a; [and] (C) to administer the immunization program described
317 in section 19a-7f; and (D) to provide services needed to collect up-to-
318 date information on childhood immunizations for all children enrolled
319 in Medicaid who reach two years of age during the year preceding the
320 current fiscal year, to incorporate such information into the childhood
321 immunization registry, as defined in section 19a-7h, and (2) inform the
322 Insurance Commissioner of such amount.

323 Sec. 5. Section 19a-639 of the general statutes is repealed and the
324 following is substituted in lieu thereof (*Effective October 1, 2013*):

325 (a) In any deliberations involving a certificate of need application
326 filed pursuant to section 19a-638, the office shall take into
327 consideration and make written findings concerning each of the
328 following guidelines and principles:

329 (1) Whether the proposed project is consistent with any applicable
330 policies and standards adopted in regulations by the Department of
331 Public Health;

332 (2) The relationship of the proposed project to the state-wide health
333 care facilities and services plan;

334 (3) Whether there is a clear public need for the health care facility or
335 services proposed by the applicant;

336 (4) Whether the applicant has satisfactorily demonstrated how the
337 proposal will impact the financial strength of the health care system in
338 the state or that the proposal is financially feasible for the applicant;

339 (5) Whether the applicant has satisfactorily demonstrated how the
340 proposal will improve quality, accessibility and cost effectiveness of
341 health care delivery in the region, including, but not limited to, (A)
342 provision of or any change in the access to services for Medicaid
343 recipients and indigent persons, and (B) the impact upon the cost
344 effectiveness of providing access to services provided under the

345 Medicaid program;

346 (6) The applicant's past and proposed provision of health care
347 services to relevant patient populations and payer mix, including, but
348 not limited to, access to services by Medicaid recipients and indigent
349 persons;

350 (7) Whether the applicant has satisfactorily identified the population
351 to be served by the proposed project and satisfactorily demonstrated
352 that the identified population has a need for the proposed services;

353 (8) The utilization of existing health care facilities and health care
354 services in the service area of the applicant; [and]

355 (9) Whether the applicant has satisfactorily demonstrated that the
356 proposed project shall not result in an unnecessary duplication of
357 existing or approved health care services or facilities; [.] and

358 (10) Whether an applicant, who has failed to provide or reduced
359 access to services by Medicaid recipients or indigent persons, has
360 demonstrated good cause for doing so, which shall not be
361 demonstrated solely on the basis of differences in reimbursement rates
362 between Medicaid and other health care payers.

363 (b) The office, as it deems necessary, may revise or supplement the
364 guidelines and principles through regulation prescribed in subsection
365 (a) of this section.

366 Sec. 6. Section 19a-127k of the general statutes is repealed and the
367 following is substituted in lieu thereof (*Effective October 1, 2013*):

368 (a) As used in this section:

369 (1) "Community benefits program" means any voluntary program to
370 promote preventive care and to improve the health status for working
371 families and populations at risk in the communities within the
372 geographic service areas of a managed care organization or a hospital
373 in accordance with guidelines established pursuant to subsection [(c)]

374 (e) of this section;

375 (2) "Community health needs assessment" means the needs
376 assessment that a hospital organization is required to conduct every
377 three years pursuant to Section 501(c)(3) of the Internal Revenue Code
378 of 1986, or any subsequent corresponding internal revenue code of the
379 United States, as amended from time to time;

380 [(2)] (3) "Managed care organization" has the same meaning as
381 provided in section 38a-478;

382 [(3)] (4) "Hospital" has the same meaning as provided in section 19a-
383 490; [.]

384 (5) "Hospital organization" means a hospital that is or seeks to be
385 recognized under Section 501(c)(3) of the Internal Revenue Code of
386 1986, or any subsequent corresponding internal revenue code of the
387 United States, as amended from time to time;

388 (6) "Widely available to the public" has the same meaning as in
389 guidelines issued by the United States Internal Revenue Service.

390 (b) Not later than January 1, 2014, each hospital organization shall
391 make its community health needs assessment widely available to the
392 public not later than fifteen days after submission to the United States
393 Internal Revenue Service. Following completion of the initial
394 community health needs assessment, each hospital organization, in
395 accordance with the Internal Revenue Service requirements, shall
396 complete and make widely available to the public an assessment once
397 every three years. Unless contained in its community health needs
398 assessment, a hospital organization shall make available to the public a
399 description of the community served by the hospital organization,
400 including a geographic description, a description of the general
401 population served by the hospital organization and information
402 concerning the leading causes of death, levels of chronic illness, and
403 descriptions of the medically underserved, low-income, minority and
404 chronically ill populations in the community.

405 (c) Each hospital organization shall make widely available to the
406 public a community benefit implementation strategy not later than one
407 year after completing its community health needs assessment. In
408 developing the community benefit implementation strategy, the
409 hospital organization shall consult with community-based
410 organizations and stakeholders, and local public health jurisdictions,
411 as well as any additional consultations the hospital decides to
412 undertake. Unless contained in the community benefit implementation
413 strategy, the hospital organization shall provide a brief explanation for
414 not accepting recommendations for community benefit proposals
415 identified in the community health needs assessment through the
416 stakeholder consultation process, such as excessive expense to
417 implement or infeasibility of implementation of the proposal.
418 Community benefit implementation strategies shall be evidence-based,
419 when available, or development and implementation of innovative
420 programs and practices shall be supported by evaluation measures.

421 [(b)] (d) On or before January 1, 2005, and biennially thereafter, each
422 managed care organization and each hospital shall submit to the
423 Healthcare Advocate, or the Healthcare Advocate's designee, a report
424 on whether the managed care organization or hospital has in place a
425 community benefits program. If a managed care organization or
426 hospital elects to develop a community benefits program, the report
427 required by this subsection shall comply with the reporting
428 requirements of subsection [(d)] (f) of this section.

429 [(c)] (e) A managed care organization or hospital may develop
430 community benefit guidelines intended to promote preventive care
431 and to improve the health status for working families and populations
432 at risk, whether or not those individuals are enrollees of the managed
433 care plan or patients of the hospital. The guidelines shall focus on the
434 following principles:

435 (1) Adoption and publication of a community benefits policy
436 statement setting forth the organization's or hospital's commitment to
437 a formal community benefits program;

438 (2) The responsibility for overseeing the development and
439 implementation of the community benefits program, the resources to
440 be allocated and the administrative mechanisms for the regular
441 evaluation of the program;

442 (3) Seeking assistance and meaningful participation from the
443 communities within the organization's or hospital's geographic service
444 areas in developing and implementing the program and in defining
445 the targeted populations and the specific health care needs it should
446 address. In doing so, the governing body or management of the
447 organization or hospital shall give priority to the public health needs
448 outlined in the most recent version of the state health plan prepared by
449 the Department of Public Health pursuant to section 19a-7; and

450 (4) Developing its program based upon an assessment of the health
451 care needs and resources of the targeted populations, particularly low
452 and middle-income, medically underserved populations and barriers
453 to accessing health care, including, but not limited to, cultural,
454 linguistic and physical barriers to accessible health care, lack of
455 information on available sources of health care coverage and services,
456 and the benefits of preventive health care. The program shall consider
457 the health care needs of a broad spectrum of age groups and health
458 conditions.

459 [(d)] (f) Each managed care organization and each hospital that
460 chooses to participate in developing a community benefits program
461 shall include in the biennial report required by subsection [(b)] (d) of
462 this section the status of the program, if any, that the organization or
463 hospital established. If the managed care organization or hospital has
464 chosen to participate in a community benefits program, the report shall
465 include the following components: (1) The community benefits policy
466 statement of the managed care organization or hospital; (2) the
467 mechanism by which community participation is solicited and
468 incorporated in the community benefits program; (3) identification of
469 community health needs that were considered in developing and
470 implementing the community benefits program; (4) a narrative

471 description of the community benefits, community services, and
472 preventive health education provided or proposed, which may include
473 measurements related to the number of people served and health
474 status outcomes; (5) measures taken to evaluate the results of the
475 community benefits program and proposed revisions to the program;
476 (6) to the extent feasible, a community benefits budget and a good faith
477 effort to measure expenditures and administrative costs associated
478 with the community benefits program, including both cash and in-
479 kind commitments; and (7) a summary of the extent to which the
480 managed care organization or hospital has developed and met the
481 guidelines listed in subsection [(c)] (e) of this section. Each managed
482 care organization and each hospital shall make a copy of the report
483 available, upon request, to any member of the public.

484 [(e)] (g) The Healthcare Advocate, or the Healthcare Advocate's
485 designee, shall, within available appropriations, develop a summary
486 and analysis of the community benefits program reports submitted by
487 managed care organizations and hospitals under this section and shall
488 review such reports for adherence to the guidelines set forth in
489 subsection [(c)] (e) of this section. Not later than October 1, 2005, and
490 biennially thereafter, the Healthcare Advocate, or the Healthcare
491 Advocate's designee, shall make such summary and analysis available
492 to the public upon request.

493 [(f)] (h) The Healthcare Advocate may, after notice and opportunity
494 for a hearing, in accordance with chapter 54, impose a civil penalty on
495 any managed care organization or hospital that fails to submit the
496 report required pursuant to this section by the date specified in
497 subsection [(b)] (d) of this section. Such penalty shall be not more than
498 fifty dollars a day for each day after the required submittal date that
499 such report is not submitted.

500 Sec. 7. Subsection (b) of section 19a-323 of the general statutes is
501 repealed and the following is substituted in lieu thereof (*Effective July*
502 *1, 2013*):

503 (b) If death occurred in this state, the death certificate required by

504 law shall be filed with the registrar of vital statistics for the town in
505 which such person died, if known, or, if not known, for the town in
506 which the body was found. The Chief Medical Examiner, Deputy Chief
507 Medical Examiner, associate medical examiner, an authorized assistant
508 medical examiner or other authorized designee shall complete the
509 cremation certificate, stating that such medical examiner or other
510 authorized designee has made inquiry into the cause and manner of
511 death and is of the opinion that no further examination or judicial
512 inquiry is necessary. The cremation certificate shall be submitted to the
513 registrar of vital statistics of the town in which such person died, if
514 known, or, if not known, of the town in which the body was found, or
515 with the registrar of vital statistics of the town in which the funeral
516 director having charge of the body is located. Upon receipt of the
517 cremation certificate, the registrar shall authorize such certificate, keep
518 such certificate on permanent record, and issue a cremation permit,
519 except that if the cremation certificate is submitted to the registrar of
520 the town where the funeral director is located, such certificate shall be
521 forwarded to the registrar of the town where the person died to be
522 kept on permanent record. If a cremation permit must be obtained
523 during the hours that the office of the local registrar of the town where
524 death occurred is closed, a subregistrar appointed to serve such town
525 may authorize such cremation permit upon receipt and review of a
526 properly completed cremation permit and cremation certificate. A
527 subregistrar who is licensed as a funeral director or embalmer
528 pursuant to chapter 385, or the employee or agent of such funeral
529 director or embalmer shall not issue a cremation permit to himself or
530 herself. A subregistrar shall forward the cremation certificate to the
531 local registrar of the town where death occurred, not later than seven
532 days after receiving such certificate. The estate of the deceased person,
533 if any, shall pay the sum of one hundred fifty dollars for the issuance
534 of the cremation certificate, provided the Office of the Chief Medical
535 Examiner shall not assess any fees for costs that are associated with the
536 cremation of a stillborn fetus. Upon request of the Chief Medical
537 Examiner, the Secretary of the Office of Policy and Management may
538 waive payment of such cremation certificate fee. No cremation

539 certificate shall be required for a permit to cremate the remains of
 540 bodies pursuant to section 19a-270a. When the cremation certificate is
 541 submitted to a town other than that where the person died, the
 542 registrar of vital statistics for such other town shall ascertain from the
 543 original removal, transit and burial permit that the certificates required
 544 by the state statutes have been received and recorded, that the body
 545 has been prepared in accordance with the Public Health Code and that
 546 the entry regarding the place of disposal is correct. Whenever the
 547 registrar finds that the place of disposal is incorrect, the registrar shall
 548 issue a corrected removal, transit and burial permit and, after
 549 inscribing and recording the original permit in the manner prescribed
 550 for sextons' reports under section 7-66, shall then immediately give
 551 written notice to the registrar for the town where the death occurred of
 552 the change in place of disposal stating the name and place of the
 553 crematory and the date of cremation. Such written notice shall be
 554 sufficient authorization to correct these items on the original certificate
 555 of death. The fee for a cremation permit shall be three dollars and for
 556 the written notice one dollar. The Department of Public Health shall
 557 provide forms for cremation permits, which shall not be the same as
 558 for regular burial permits and shall include space to record
 559 information about the intended manner of disposition of the cremated
 560 remains, and such blanks and books as may be required by the
 561 registrars.

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>July 1, 2013</i>	19a-491
Sec. 2	<i>October 1, 2013</i>	19a-88
Sec. 3	<i>July 1, 2013</i>	New section
Sec. 4	<i>July 1, 2013</i>	19a-7j(a)
Sec. 5	<i>October 1, 2013</i>	19a-639
Sec. 6	<i>October 1, 2013</i>	19a-127k
Sec. 7	<i>July 1, 2013</i>	19a-323(b)

Statement of Legislative Commissioners:

In section 6(b), the phrases "served by the hospital" were changed to "served by the hospital organization", for internal consistency.

PH *Joint Favorable Subst.*

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 14 \$	FY 15 \$
Public Health, Dept.	GF - Revenue Gain	119,800	144,100
Office of the Chief Medical Examiner	GF - Potential Revenue Loss	less than 1,000	less than 1,000

Municipal Impact: None

Explanation

The bill results in a Department of Public Health (DPH) General Fund (GF) revenue gain of approximately \$119,800 in FY 14 and \$144,100 in FY 15 and a potential minimal GF revenue loss in both FY 14 and FY 15. A section by section discussion of the bill's fiscal impacts is provided below.

Section 1 establishes fees for home health care agencies of \$300, satellite patient service offices of \$100 and assisted living services agencies of \$500, all of which are already licensed by DPH, resulting in a General Fund revenue gain of approximately \$36,600 in both FY 14 and FY 15. It also expands the fee for DPH technical assistance provided for the design, review and development of an institution's construction, sale or change in ownership to include technical assistance provided for an institution's renovation and building alteration. Under this section, any such technical assistance provided on a project costing \$1 million or less remains at the existing fee of \$565. For projects costing more than \$1 million, the fee is established at $\frac{1}{4}$ of 1% of the total project cost. It is estimated that this will result in approximately \$10,000 in additional General Fund revenue

annually.

Section 2 increases license renewal fees by \$5 for physicians, surgeons, nurses, nurse midwives and dentists and requires, instead of allowing, all of these professions, except nurse midwives, to renew their licenses online. While existing legislation allows DPH to charge a service fee of up to \$5, the agency has not done so. As such, after accounting for costs for online transactions (approximately 2%) for the professions required to renew their license online, the net General Fund revenue gain associated with this fee increase is estimated at \$73,200 in FY 14 and \$97,500 in FY 15.

Section 3 requires DPH, within available appropriations, to establish and administer a program to provide financial assistance to community health centers. As DPH already does so, there is no fiscal impact from this requirement. It also requires DPH to establish a formula to disburse funds within this program, which the agency is currently working to establish.

Section 4 expands the Office of Policy and Management's (OPM's) assessment of the amount to be appropriated for the state childhood vaccine program to include administrative costs, which does not result in a net state fiscal impact. With this change, administrative costs would be offset by increased General Fund revenue through the annual assessment of private entities doing health insurance business in the state.

Section 5 requires DPH's Office of Health Care Access to consider an applicant's provision of services to Medicaid recipients when considering certificate of need applications and does not result in a fiscal impact. Likewise **Section 6**, which requires nonprofit hospitals to make their community health needs assessment an implementation strategy available to the public, does not result in a fiscal impact.

Section 7 allows the Secretary of OPM at the request of the Chief Medical Examiner to waive a \$150 cremation fee resulting in a potential minimal General Fund revenue loss. While it is unknown

how many such fees will be waived in FY 14 and FY 15, it is anticipated that the associated revenue loss would be less than \$1,000 annually.

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to the number of physicians, surgeons, nurses, nurse midwives and dentists renewing their DPH-issued licenses and the number of cremation fees waived by the Secretary of OPM.

OLR Bill Analysis**sSB 848*****AN ACT IMPLEMENTING PROVISIONS OF THE BUDGET
CONCERNING PUBLIC HEALTH.*****SUMMARY:**

This bill makes various changes to the public health statutes. It:

1. establishes licensing and inspection fees for home health care agencies and assisted living service agencies (§ 1);
2. increases the fee the Department of Public Health (DPH) can charge for the technical assistance it provides for the design, review, and development of certain health care facilities' construction (§ 1);
3. increases the license renewal fee by \$5 for physicians, surgeons, nurses, nurse-midwives, and dentists and requires all except nurse midwives to renew their licenses online (§ 2);
4. requires DPH, within available appropriations, to establish and administer a program to provide financial assistance to community health centers and establish a formula to disburse funds based on the care centers provide (§ 3);
5. requires the Office of Policy and Management (OPM) secretary to annually determine the amount appropriated to administer the Connecticut Vaccine Program (§ 4);
6. requires DPH's Office of Health Care Access (OHCA) to consider, when evaluating a certificate of need (CON) application, the applicant's provision of services to Medicaid recipients and indigent people (§ 5);

7. requires nonprofit hospitals to make widely available to the public the community health needs assessment and implementation strategy they are required to complete every third year under federal law (§ 6); and
8. allows the OPM secretary, at the Chief Medical Examiner's request, to waive the \$150 cremation certificate fee required for the cremation of a body for which a death certificate has been issued (§ 7).

EFFECTIVE DATE: July 1, 2013, except for the provisions on the (1) increased license renewal fees and online licensure, (2) CON, and (3) cremation fee waiver, which take effect October 1, 2013.

§ 1 – LICENSURE FEES FOR HOME HEALTH CARE AGENCIES AND ASSISTED LIVING FACILITIES

The bill establishes a licensing and inspection fee for home health care agencies of \$300 per agency and \$100 per satellite office. The fee must be paid biennially to DPH, except for Medicare- and Medicaid-certified agencies, which are licensed and inspected triennially.

The bill also establishes a \$500 biennial licensing and inspection fee for assisted living services agencies, except those participating in the state's congregate housing pilot program in Norwich.

§ 1 – HEALTH CARE FACILITY TECHNICAL ASSISTANCE FEE

By law, the DPH commissioner may charge a \$565 fee for technical assistance the department provides for the design, review, and development of a health care facility's construction, sale, or ownership change. The bill allows the commissioner to also charge this fee for technical assistance provided on a facility's renovation or building alteration.

The bill applies the \$565 fee only to projects costing \$1 million or less. For projects costing more than this amount, the bill allows the commissioner to charge one-quarter of 1% of the total project cost.

The bill specifies that the fee includes all DPH reviews and on-site

inspections and does not apply to state-owned facilities.

§ 2 – ONLINE LICENSURE RENEWAL AND INCREASED FEES

The bill requires, rather than allows, physicians, surgeons, nurses and dentists to renew their licenses using DPH’s online license renewal system. It increases their renewal fee by \$5 (presumably to cover the associated transaction fees). It removes the provision in current law allowing the department to charge a \$5 service fee for online license renewals.

The bill increases the license renewal fee by \$5 for nurse-midwives, but does not require them to renew their licenses online.

It also removes an obsolete DPH reporting requirement regarding the online license renewal system.

§ 3 – FINANCIAL ASSISTANCE FOR COMMUNITY HEALTH CENTERS

The bill requires the DPH commissioner, within available appropriations, to establish and administer a financial assistance program for community health centers.

The commissioner must establish a formula to disburse program funds to the centers, which must include (1) the number of uninsured patients the center serves and (2) the types of services it provides.

The bill allows the commissioner to establish program participation requirements, provided she gives reasonable notice of the requirements to all community health centers. Centers may only use the funds for commissioner-approved purposes.

The bill defines a “community health center” as a public or private nonprofit medical care facility that (1) meets community health center statutory requirements and (2) is designated by the U.S. Department of Health and Human Services as a federally qualified health center (FQHC) or FQHC look-alike (i.e., is eligible for but does not receive federal Public Health Service Act Section 330 grant funds).

§ 4 – CONNECTICUT VACCINE PROGRAM

The bill requires the OPM secretary, in consultation with the DPH commissioner, to determine annually by September 1 the amount of the General Fund appropriation to administer the Connecticut Vaccine Program (CVP) and inform the insurance commissioner of the amount. The law already requires the secretary to annually determine the appropriated amount to purchase, store, and distribute vaccines under the program and inform the insurance commissioner.

The CVP is a state- and federally-funded program that provides certain childhood vaccinations at no cost to health care providers. The state-funded component is funded by an assessment on certain health insurers and third-party administrators.

§ 5 – CERTIFICATE OF NEED (CON)

The bill adds to those factors OHCA must consider when evaluating a CON application whether an applicant who failed to provide, or reduced access to, services by Medicaid recipients or indigent people demonstrated good cause for doing so. It specifies that good cause is not demonstrated solely based on differences in reimbursement rates between Medicaid and other health care payers.

By law, OHCA must consider several factors when evaluating a CON application, including the applicant's past and proposed provision of health care services to relevant patient populations and payer mix. The bill specifies that this includes access to services by Medicaid recipients and indigent people.

The law requires OHCA to also consider, among other things, whether the applicant satisfactorily demonstrated how the proposal will improve the quality, accessibility, and cost effectiveness of health care delivery in the region. The bill specifies that this includes the (1) provision of, or change in, access to services for Medicaid recipients and indigent people and (2) impact on the cost effectiveness of providing access to Medicaid services.

§ 6 – COMMUNITY HEALTH NEEDS ASSESSMENT

Requirements

Federal health care reform law requires non-profit hospitals to triennially submit to the Internal Revenue Service (IRS) (1) a community health needs assessment and (2) an implementation strategy to meet the health needs the assessment identifies. The bill requires these hospitals, by January 1, 2014, to make the assessment widely available to the public (as defined in IRS guidelines) within 15 days after submitting it to the IRS. After completing the initial assessment, the bill requires hospitals to do this once every three years.

The bill requires non-profit hospitals to make publicly available, unless it is contained in the assessment, a description of the community they serve. This must include (1) a geographic description; (2) a description of the general population served; (3) information on the leading causes of death; (4) chronic illness levels; (5) and descriptions of the community's medically underserved, low-income, minority, and chronically ill populations.

Implementation Strategy

Federal law requires non-profit hospitals to complete an implementation strategy within the same tax year as the community health needs assessment. The strategy is a written plan addressing each health need identified in the assessment by (1) describing how the hospital plans to meet the need or (2) identifying the need as one it does not intend to meet and explaining why.

The bill requires these hospitals to make the strategy widely available to the public within one year after completing the assessment. In developing the strategy, the hospital must consult with community-based organizations and stakeholders, local public health jurisdictions, and any others it chooses.

Hospitals must provide, unless it is contained in the strategy, a brief explanation for not accepting recommendations for proposals identified in the community health needs assessment through the stakeholder consultation process, such as the proposal's excessive cost

or infeasibility. It requires (1) strategies to be evidence-based, when available or (2) the development and implementation of innovative programs and practices to be supported by evaluation measures.

BACKGROUND

Related Bill

sSB 1066, favorably reported by the Public Health Committee, requires OHCA to consider, when evaluating a CON application, whether the proposal is consistent with the overall goals of federal health care reform.

COMMITTEE ACTION

Public Health Committee

Joint Favorable Substitute

Yea 18 Nay 9 (04/02/2013)